



Send completed forms to DOH Communicable Disease Epidemiology  
Fax: 206-418-5515

LHJ Use ID \_\_\_\_\_

☐ Reported to DOH

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

LHJ Classification

☐ Confirmed

☐ Probable

By: ☐ Lab ☐ Clinical

☐ Other: \_\_\_\_\_

Outbreak # (LHJ) \_\_\_\_\_ (DOH) \_\_\_\_\_

DOH Use ID \_\_\_\_\_

Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_

DOH Classification

☐ Confirmed

☐ Probable

☐ No count; reason: \_\_\_\_\_

# Tetanus

County \_\_\_\_\_

## REPORT SOURCE

Initial report date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reporter name \_\_\_\_\_

Reporter phone \_\_\_\_\_

Primary HCP name \_\_\_\_\_

Primary HCP phone \_\_\_\_\_

## PATIENT INFORMATION

Name (last, first) \_\_\_\_\_

Address \_\_\_\_\_ ☐ Homeless

City/State/Zip \_\_\_\_\_

Phone(s)/Email \_\_\_\_\_

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Occupation/grade \_\_\_\_\_

Employer/worksite \_\_\_\_\_ School/child care name \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

## CLINICAL INFORMATION

Onset date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Derived

Diagnosis date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Illness duration: \_\_\_\_\_ days

### Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ Painful muscle spasms

☐ ☐ ☐ ☐ Lockjaw

### Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Contaminated wound during the three months before onset of symptoms.

☐ ☐ ☐ ☐ Skin lesion prior to illness:

☐ Abscess ☐ Ulcer ☐ Blister ☐ Gangrene

☐ Cellulitis ☐ Other: \_\_\_\_\_

☐ ☐ ☐ ☐ Immunosuppressive therapy or disease

☐ ☐ ☐ ☐ Chronic diabetes

### Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ Acute hypertonia

☐ ☐ ☐ ☐ Risus sardonicus (facial muscle spasms)

☐ ☐ ☐ ☐ Opisthotonus (whole back spasm and bowing)

☐ ☐ ☐ ☐ Mechanical ventilation or intubation required during hospitalization

☐ ☐ ☐ ☐ Admitted to intensive care unit

Days in ICU: \_\_\_\_\_

### Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name \_\_\_\_\_

Admit date \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge date \_\_\_\_/\_\_\_\_/\_\_\_\_

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ ☐ ☐ Autopsy Place of death \_\_\_\_\_

### Vaccination

P = Positive O = Other, unknown

N = Negative NT = Not Tested

I = Indeterminate

P N I O NT

☐ ☐ ☐ ☐ ☐ Vaccine up to date for tetanus

Date last vaccine prior to illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

# doses tetanus vaccine prior to illness: \_\_\_\_\_

Vaccine series not up to date reason:

☐ Religious exemption

☐ Medical contraindication

☐ Philosophical exemption

☐ Previous infection confirmed by laboratory

☐ Previous infection confirmed by physician

☐ Parental refusal ☐ Under age for vaccination

☐ Other: \_\_\_\_\_

☐ Unknown

## NOTES

**INFECTION TIMELINE**

Enter onset date/time  
(first sx) in heavy box.  
Count backward to  
determine probable  
exposure period

Days from  
onset:

Exposure period\*

- 21 -3

o  
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t

Calendar date/time:

\* This is the usual incubation period,  
though it may be as short as one  
day or as long as several months

**EXPOSURE (Refer to dates above)**

**Y N DK NA**

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or  
outside of usual routine  
Out of: ☐ County ☐ State ☐ Country  
Dates/Locations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Y N DK NA**

- ☐ ☐ ☐ ☐ Insulin-dependent diabetic  
☐ ☐ ☐ ☐ Non-injection street drug use  
☐ ☐ ☐ ☐ Injection street drug use  
Injection street drug use type: \_\_\_\_\_  
☐ ☐ ☐ ☐ Neonate Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Age of mother: \_\_\_\_\_  
Location of birth: ☐ Home ☐ Hospital  
☐ Other: \_\_\_\_\_  
Attended by: ☐ Physician ☐ Nurse  
☐ Licensed midwife ☐ Unlicensed midwife  
☐ Other: \_\_\_\_\_ ☐ Unk  
Mother received tetanus toxoid prior to infant  
illness ☐ Y ☐ N ☐ DK ☐ NA  
Last dose: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Patient could not be interviewed

☐ No risk factors or exposures could be identified

**Y N DK NA**

- ☐ ☐ ☐ ☐ Recent acute wound (past 3 months)  
Date identified: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Wound site:  
☐ Head ☐ Trunk ☐ Upper extremity  
☐ Lower extremity ☐ Other: \_\_\_\_\_  
☐ Unspecified  
Wound type:  
☐ Punctate ☐ Crush ☐ Abrasion ☐ Avulsion  
☐ Stellate laceration ☐ Linear laceration  
☐ Burn ☐ Frostbite ☐ Compound fracture  
☐ Surgery ☐ Animal bite ☐ Insect bite  
☐ Tissue necrosis ☐ Dental ☐ Unk  
☐ Other: \_\_\_\_\_  
Depth of wound: \_\_\_\_\_  
Wound contaminated ☐ Y ☐ N ☐ DK ☐ NA  
Signs of infection ☐ Y ☐ N ☐ DK ☐ NA  
Wound debrided ☐ Y ☐ N ☐ DK ☐ NA  
If so, how soon after wound received: \_\_\_\_\_  
☐ ☐ ☐ ☐ Injury related  
Environment of injury:  
☐ Home ☐ Other indoors ☐ Farm/yard  
☐ Automobile ☐ Other outdoors ☐ Unk  
Work related ☐ Y ☐ N ☐ DK ☐ NA

Most likely exposure/site: \_\_\_\_\_

Site name/address: \_\_\_\_\_

Where did exposure probably occur? ☐ In WA (County: \_\_\_\_\_) ☐ US but not WA ☐ Not in US ☐ Unk

**PATIENT PROPHYLAXIS AND TREATMENT**

Tetanus toxoid given as therapy

☐ Y ☐ N ☐ DK ☐ NA

Date/time given: \_\_\_\_/\_\_\_\_/\_\_\_\_ AM / PM

Tetanus IG given prior to onset

☐ Y ☐ N ☐ DK ☐ NA

Date/time given: \_\_\_\_/\_\_\_\_/\_\_\_\_ AM / PM Dose: \_\_\_\_\_ Units

**PUBLIC HEALTH ISSUES**

**Y N DK NA**

- ☐ ☐ ☐ ☐ Outbreak related  
☐ ☐ ☐ ☐ Contaminated street drugs

**PUBLIC HEALTH ACTIONS**

- ☐ Initiate trace-back investigation  
☐ Trace contaminated drugs  
☐ Referral to physician  
☐ Other, specify: \_\_\_\_\_

**NOTES**

Investigator \_\_\_\_\_ Phone/email: \_\_\_\_\_

Investigation complete date \_\_\_\_/\_\_\_\_/\_\_\_\_

Local health jurisdiction \_\_\_\_\_

Record complete date \_\_\_\_/\_\_\_\_/\_\_\_\_